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INTEREST AND LIMITS IN EVALUATION OF COGNITIVE DISORDERS FOR THE ELDERLY

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Introduction : Why ?

- Population's Ageing is a Public Health issue and dementia for the Elderly a reality
- Examination of cognitive disorders for the Elderly are done to help them to have the better ageing possible in spite of Alzheimer disease and related disorders, Parkinson disease, psychiatric and/or addictive disorders, and also to reassure people with no cognitive troubles to prevent pathological ageing.
- But the way to do it is what is the most important, taking care of each subject in his own history.

Who is requesting it ?

It can be :

- Either a subject who comes by himself
- Or a family which is in difficulties with an old relative
- Or a general practitioner or a hospital MD
- Or a care provider in institution for the elderly

How is it done ?

- With first interview using MMSE or MOCA tests with a Doctor qualified in Gerontology and Neuropsychology who works with a Neuropsychologist to have an idea of the complaint.
- And history of the patient (Medical and Psychological with questions of the person's biography)

Which data are required ?

- Patients and care givers ' self-questionnaires if someone of the family is present
- Imaging (MRI scan, functional MRI)
- Cerebrospinal fluid markers
- Neuropsychology assessment : memory, language, executives functions, troubles of behaviour…
- Depression state using DSM V or ICD 10's criteria

Specificity of consultations in institutions

- Firstly, it's necessary to provide a preliminary training of nurses

The question is : why is the assessment required ?

- Then we process to clinical interviews of the elderly persons and to an assessment using simple standardized tests
- Liaison with the main care provider*

Evaluations for Research in Epidemiology

- First, we need the opinion of practitioners to eliminate contraindications
- Then, we write a letter to inform the elderly person taking part in the research and his informant explaining why the study is carried out.
- Finally, a cognitive assessment is done that can be linked to factors of risk and protection.

Decisional tree with MMSE

- If MMSE > 17 : complete battery of tests
- If MMSE is between 10 and 17 : simple standardized tests
- If MMSE < 10 : no more tests (case of severe Dementia)

Management goals for patients with cognitive complaint*

For all patients with cognitive complaint, we have 3 mains goals :

1/ Maintening function and independence

2/ Preventing further cognitive decline

3/ Ensuring quality of life

Subjective cognitive impairment

For this patients, the goals are :

- Reassurance
- Optimizing management of comorbidities
- Promoting a healthy lifestyle

However, they should be monitored carefully for any signs of progression predictive of future MCI.

Mild Cognitive Impairment (MCI) (1)

An important goal to achieve is accepting the uncertainty surrounding this diagnosis given the possibility of either progression, or stability, or even improvement.

Other goals to consider as well are :

Mild Cognitive Impairment (MCI) (2)

- Optimizing management of comorbidities and especially treat vascular risk factors
- Minimizing medications affecting cognitive functions
- Promoting physical and mental health
- Building a partenership with patient and caregiver to establish a safety net and advance care planning.

Dementia

- Caregiver support becomes increasingly important as disease progresses and dependance increases
- Vigilance and early intervention for neuropsychiatric symptoms, sleep disturbance and incontinence…
- Meeting patient's goals for end-of-life care.

*Nonpharmacologic Strategies

- To date, no nonpharmacologic interventions have been shown to prevent further decline in patients with either subjective cognitive impairment or MCI.
- On the other hand, numerous nonpharmacologic interventions targeting patients with dementia, their caregiver or the patient-caregiver dyad have been investigated.

Physical exercises

Possible mechanisms by which exercise may improve or maintain cognitive function include :

- Improving central adiposity and insulin resistance
- Decreasing oxydative stress
- Improving vascular function
- Increasing cerebral blood flow

Cognitive stimulation

- Cognitive stimulation uses enjoyable activities to engage memory and concentration in a social setting.
- Two of the larger studies using this approach reported improvements in cognitive functions and quality of life, but not in functional status, mood, or behavioral symptoms.

Cognitive training

- To date « brain training » programs have not provided strong evidence of benefit on cognition, function or mood in patients with mild to moderate dementia.
- Patients and caregivers should be cautioned against expensive programs that promise to prevent or reverse dementia.

Cognitive reframing for carers

- It's a component of Cognitive Behavioral Therapy (CBT)
- It focuses on caregiver's maladaptative, self defeating or distressing cognition about their relative behavior
- It focuses also on their own performance in the caring role

Conclusion

- Neuropsychological evaluation is very useful to help doing diagnosis as precisely as possible in Alzheimer disease and related disorders
- But to date, there are too few studies to show how to treat patients with MCI diagnosis and subjective cognitive impairment. So, preventing Alzheimer disease and related disorders is almost impossible.

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